WestVirginiaUniversity
ROBERT C. BYRD HEALTH SCIENCES CENTER

June 30, 2005

Ms. Moya Thompson,
Director of Outreach Coordinator
White House Conference on Aging
4350 East West Highway, 3rd Floor
Bethesda, MD 20814

Dear Ms. Thompson,

We are enclosing the report on our White House Conference on Aging Pre-Conference sanctioned event held on May 27, 2005 in Morgantown, WV.

We believe the conference was a highly substantive and productive event, attracting a wide audience and nationally prominent speakers.

We trust the event will further the agenda and mission of the conference and we eagerly look forward to ongoing participation and input.

Sincerely,

David K. Brown, Ph.D.

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Associate Director for Education, WVU Center on Aging

Center on Aging

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2005 White House Conference on Aging
Post-Event Summary Report

Name of Event:	Rural Culture: West Virginia's Legacy		
Date of Event:	May 25-27, 2005		
Location of Event:	Radisson Waterfront Hotel, Morgantown, WV		
Number of Persons attending:	97		
Sponsoring Organization(s):	Mountain State Geriatric Education Center, West Virginia University Center on Aging at the Robert C. Byrd Health Sciences Center.		
Contact Name:	Sara Jane Gainor, Program Director, Mountain State GEC		
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Priority Issue # 1

John A. Krout, Ph.D., Director and Professor, Ithaca College Gerontology Institute, Ithaca College, NY 14850

Priority Issue: Ensure that older rural adults have the support they need to remain in their homes as long as possible or, at a minimum, have access to comparable long-term care options as other elders have.

Potential Barriers: The programs that are needed exist, but are often not available in small communities, especially more remote and small places. Low population density and small numbers of clients mean fewer people can be served with a finite number of dollars. Many rural elders rely on family, friends and neighbors, but this network is increasingly at risk as young adults leave to find work in larger communities and healthier and younger elders move seasonally or permanently to places with more services. Gaps in services often reduce the effectiveness of services that are available. Existing programs are under funded and can be hampered by regulations and guidelines more appropriate for larger communities and service markets.

Proposed Solutions: First, more Medicaid waivers and flexibility on how that money is spent. One example would be the "Pioneers" in Rochester N.Y. that uses homes, appropriately staffed, to be used as a nursing home. Nursing homes could then open "satellites" in very small rural communities and allow small town elders to at least stay in their communities if they need nursing home care. Second, provide more dollars for "consumer directed care" which recognizes the preferences of older adults and allows them to pay local people and family ("nonprofessionals") to provide "services." Third, SUA's and AAA's should be given more flexibility on how they spend OAA and other dollars- say to shift funds more easily between Title III programs and support programs like home sharing and elder cottages. Fourth, state licensure and construction regulations for housing options such as life care communities and

assisted living should be examined and retooled to be more cost effective and flexible for small size and density senior housing development and operation. Surely ways can be found to meet safety and care concerns that are less expensive and thus make building and operating supportive housing for seniors in small communities more feasible and cost-effective. Fifth, insurance regulations that might decrease the use of volunteers in a variety of programs (such as using private vehicles to provide para-transit) should be identified and modified. Sixth, states and the federal government should provide incentives for consortium of hospitals, nursing homes and other community agencies to build assisted living, elder cottages and other alternatives to traditional nursing home beds. Seventh, funding for the infrastructure for and provision of tele-medicine in rural areas should be increased.

Priority Issue # 2

Jill Cochran, MSN, RN-C, FNP, Robert C. Byrd Clinic, Lewisburg, WV

Priority Issue: Primary care of the geriatric population must be culturally sensitive. The geriatric population of West Virginia has a functional definition of health; meaning that if they can function, they are well. This means the majority of visits are for illness and prevention is minimal. This means disease processes are advanced by the time treatment is sought.

Potential barriers: Barriers to culturally sensitive care. The health care providers must be aware of the belief and value system that is held by this population. Using threats or power is not a solution. Also, adherence to the plan of care can be hampered by the inability to afford or attend appointments. Understanding the medical jargon is a problem. Going to a medical facility means they "can't manage it themselves anymore." It may seem as a failure to them or as the illness taking them over.

Proposed solution: "Get them when they're sick" and take it out of the walls of the clinic. Use illness visits to perform health promotion and health maintenance. They will get to know you and know that you care about them enough to go the extra mile. Use Mid-level practitioners such as Nurse Practitioners or Physician Assistants to manage a group of geriatrics at senior centers or housing complexes and make mini office where they go on a daily basis. This personalizes the care and takes the stigma of illness away from the visit. It is done in schools and found to be very successful to have a "doctor's office" in the school. It could be similar for the senior citizens.

Priority Issue # 3

R. Turner Goins, Ph.D., Associate Professor and Associate Director for Research, West Virginia University Center on Aging, Morgantown, WV 26506-9127

Priority Issue
The meaning of health among rural older adults: Considerations for cultural competency

Background
Cultural awareness on the part of health care providers requires a sustained effort to "become appreciative and sensitive to the values, beliefs, life ways, practices, and problem-solving strategies of clients' cultures" (Campinha-Bacote, 1999, p. 204). Efforts to improve communication between providers and their clients must consider how individuals conceptualize health.

Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education, 38*(5), 203-207.

Potential Barriers
Physiological and epidemiological measurements alone fail to capture the subjective dimension of health. Descriptions of health based on these measurements ignore the idea of health as a value.

Proposed Solutions
Health care providers need to supplement medical approaches with a more contextually-sensitive recognition of rural elders' desired health goals and outcomes. This can also help with the implementation of well-designed and appropriately-targeted health promotion campaigns. A campaign designed to promote healthy behaviors in rural areas should incorporate local health-related colloquialisms in their printed materials, which might increase program acceptability and participation.

Priority Issue # 4

Hilda R. Heady, MSW, Associate Vice President for Rural Health, West Virginia University; President, National Rural Health Association

Priority Issue: Aging Rural Veterans

Background: While the national average of veterans among our total population is 12.7%, 18 predominantly rural states are well above this average ranging from a high of 16% in Montana to 14.1% in Colorado. Vietnam era veterans make up our largest veteran group at 31.7% or 8.4 million people. The current average age of the Vietnam veteran is 58 years. When asked about their physical and mental health, rural veterans rank lower in all categories than urban veterans and much lower than Americans of the same age as a whole. The Post Traumatic Stress Disorder (PTSD) rate for male Vietnam Veterans was noted at 30% and 26% for female veterans in the Vietnam Veteran Readjustment Study in 1990. The numbers for the Gulf War veterans range from 7 to 10% of males and 16-20% for females. Since it is now accepted that PTSD can be a progressive disorder, veterans as they age, may experience greater problems with the symptoms of PTSD. As veterans age it becomes essential to keep their families in tact to provide support for these veterans.

Barriers: Barriers to adequate health and mental health care for veterans is worse if that veteran lives in a rural area in this country. These barriers include transportation to VA or other health care facilities; limited primary care providers and those that are available to veterans cannot access a veteran's health records; inadequate domiciliary beds in some rural areas; inadequate

distribution of mental health providers in rural areas, and lack of awareness of the special needs of veterans by health and mental health providers.

Proposed Solutions:

1. Allocate funding to study the special and unique health and mental health needs of rural veterans with an emphasis on the aging rural veteran.
2. Provide a mechanism whereby primary care physicians who serve rural veterans can access their VA medical records.
3. Increase the number of Community Based Operated Clinics (CBOCs) in rural areas and lower the penetration ratio of veteran populations to make more rural areas eligible for designation of CBOCs.
4. Provide VA contracts with local primary care clinics, community health centers, and mental health facilities to provide services to rural veterans who cannot get these VA services within a reasonable driving distance.
5. Increase the number of domiciliary beds in rural states.
6. Provide adequate funding and require that Veteran Outreach Centers provide family therapy for veterans and their families and significant others.